Washington State Health Care Authority
Public Employees Benefits Board

2014 Medical Benefits Cost Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans, and extended-network benefits for Group Health's consumer-directed health plan (CDHP). Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions.

Annual Costs	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[2]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Deductible Applies to out-of-pocket maximum	$250/person $750/family	$350/person $1,050/ family	$1,400/person $2,800/family*		$250/person $750/family	$1,400/ person $2,800/ family*	$250/person $750/family	$1,400/ person $2,800/ family*
Out-of-pocket maximum[1]	$2,000/person $4,000/family Your deductible, copays and coinsurance for all covered services apply		$5,100/person $10,200/family** Your deductible, copays, and coinsurance for all covered services apply		$2,000/ person $4,000/family Your deductible, copays, and coinsurance for most covered services (not prescription-drug costs) apply	$4,200/ person $8,400/ family** Your deductible, copays, and coinsurance for most covered services apply	$2,000/ person $4,000/ family Your deductible, copays, and coinsurance for most covered services (not prescription-drug costs and prescription-drug deductible) apply	$4,200/ person $8,400/ family** All copays and coinsurance for covered services apply
Prescription drug deductible	None	None	Prescription-drug costs apply toward CDHP deductible.		None	Prescription-drug costs apply toward CDHP deductible.	$100/person $300/family (Tier 2 and 3 drugs)	Prescription-drug costs apply toward CDHP deductible.

*Must meet family deductible before plan pays benefits.

**Must meet family out-of-pocket maximum before plan pays 100% for covered benefits.

[1] Premiums, charges for services in excess of a benefit, charges in excess of the plan's allowed amount, coinsurance for out-of-network providers (UMP), and charges for non-covered services do not apply to out-of-pocket maximum. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

[2] Group Health's CDHP Extended Network includes First Choice Health Network, First Health Network, and its affiliated providers, and any other licensed provider in the U.S.

[3] UMP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services plus any amount the provider charges over the allowed amount.

[4] Preventive care is not covered in Group Health's CDHP Extended Network except for routine mammography screening. Annual deductible and 30% plan coinsurance applies.

[5] Contact your plan about costs for children's vision care.

The information in this document is accurate at the time of printing. Contact the plans or review the certificate of coverage before making decisions.

(continued)

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[1]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Ambulance Air or ground, per trip	20%	20%	10%	30%	15%	15%	20%	20%
Diagnostic tests, laboratory, and x-rays	$0; MRI/ CT/PET scan $30	$0; MRI/ CT/PET scan $40	10%	30%	$10	15%	15%	15%
Durable medical equipment, supplies, and prosthetics	20%	20%	10%	30%	20%	20%	15%	15%
Emergency room (copay waived if admitted)	$250	$300	10%	10%	$75	15%	$75 copay + 15%	15%
Hearing Routine annual exam	$15	$20	10%	30%	$30	$30	$0	15%
Hardware	Any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.							
Home health	$0	$0	10%	30%	15%	15%	15%	15%
Hospital services Inpatient	$150/day up to $750 maximum/ admission	$200/day up to $1,000 maximum/ admission	10%	30%	15%	15%	$200/day up to $600 maximum/ year per person + 15% professional fees	15%
Outpatient	$150	$200	10%	30%	15%	15%	15%	15%
Office visit								
Primary care	$15	$20	10%	30%	$20	$20	15%	15%
Urgent care	$15	$20	10%	30%	$40	$40	15%	15%
Specialist	$30	$40	10%	30%	$30	$30	15%	15%
Mental health	$15	$20	10%	30%	$20	$20	15%	15%
Chemotherapy	$15	$20	10%	30%	$0	$0	15%	15%
Radiation	$30	$40	10%	30%	$0	$0	15%	15%
Physical, occupational, and speech therapy (per-visit cost for 60 visits/ year combined)	$15	$20	10%	30%	$30	$30	15%	15%

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[5] Contact your plan about costs for children's vision care.

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[1]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Prescription drugs								
Retail pharmacy (up to a 30-day supply)								
Value tier	$5	$5	$5	$5	Does not apply	Does not apply	5% (up to $10/ 30-day supply)	
Tier 1	$20	$20	$20	$20	$15	$15	10% (up to $25/ 30-day supply)	15%*
Tier 2	$40	$40	$40	$40	$30	$30	30% (up to $75/30-day supply)	
Tier 3	50% up to $250	50% up to $250	50% up to $250	50% up to $250	Does not apply	Does not apply	50%* (Specialty drugs up to $150; no limit for non-specialty	
Mail order (up to a 90-day supply)								
Value tier	$10	$10	$10	Does not apply	Does not apply	Does not apply	5% (up to $30/ 90-day supply)	
Tier 1	$40	$40	$40	Does not apply	$30	$30	10% (up to $75/ 90-day supply)	
Tier 2	$80	$80	$80	Does not apply	$60	$60	30% (up to $225/ 90-day supply)	15%*
Tier 3	50% up to $750	50% up to $750	50% up to $750	Does not apply	Does not apply	Does not apply	50%* (specialty drugs up to $150; no limit for non-specialty)	
Preventive care	$0	$0	$0	Not covered[4]	$0	$0	$0	$0
See certificate of coverage or check with plan for full list of services.								
Spinal manipulations	$15	$20	10%	30%	$30	$30	15%	15%
Vision care[5] Exam (annual)	$15	$20	10%	30%	$20	$20	$0	$0
Glasses and contact lenses	Any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined. Exception: for UMP Classic any amount over $65 for contact lens fitting fees.							

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**Must meet family out-of-pocket maximum before plan pays 100% for covered benefits.